Searching Out the Hidden Precipitant and Preconscious Mental Status: The Therapeutic Assessment of Risk

Jon Berlin, MD

April 21, 2005

Psychodynamic Perspective

- The search for the *hidden acute precipitant* brings out an individual's *defended preconscious mental status* or crisis state of mind. This may provide the evaluator and subject with useful information about what the crisis is really all about and what is the actual degree of risk.

- Approaching the person with a therapeutic state of mind invites the letting down of defenses; in addition, helping him talk about his emotional pain is therapeutic. This type of assessment and its therapeutic by-product help to transform what is often an adversarial relationship into one with the beginnings of a therapeutic alliance.

- Assessing a people's ability to form an alliance and their tentative ability to manage painful feelings helps the evaluator to determine the viability of outpatient vs. inpatient management.

Standard Mental Status Exam

- Extremely useful in straightforward cases
- Other times, very unreliable. Makes assessment risk factors more important
- People may minimize, exaggerate or accurately report their level of distress

The Preconscious

- Mental processes that are simply out of awareness
- Processes that are protected from awareness by defense mechanisms but accessible with effort
- Psychodynamic interviewing operates at the border between the patient's conscious and the preconscious. (Case example of Mr. X).

Same Case, Two Scenarios

- Approach a composite case in two different ways with two different outcomes
- First approach is *phenomenological*, the second adds the *psychodynamic* component
- Both assessments can be done in a busy ER or crisis setting

“Victoria”: Approach #1

- Victoria is an almost 40 year-old, single woman in outpatient treatment for depression. She has never been married and has no children.

- She is in PCS on emergency detention for overdosing on 30 Zoloft after an argument with her boyfriend, Bill, who was out on a weekend pass from his half-way house. He noticed the empty pill bottles right away and took her to an ER where she was quickly medically stabilized.

- Evaluation reveals V. to be non-depressed and eager to go home so as not to miss work at her new job the next day. She will be driving a school bus. She has no SI, HI, psychosis or intense anxiety. She says the attempt was “stupid. I’ll never do that again.” She makes eye contact and is polite and cordial. There is a little spot of charcoal on her upper lip. She eats well and is in good health but has trouble sleeping. Bill, 28, holds her hand in the waiting room.

History

- Stressors that V. can identify include a stormy relationship with Bill, financial problems, and estrangement from her mother and stepfather. V. forgets what the argument with Bill was about but it was something petty. Her biological father was a rock musician who essentially abandoned the family when she was five. He has drug problems and resurfaces in Milwaukee occasionally when he needs money.
- Victoria has made several suicide gestures and attempts in her life, but only one serious attempt 19 years ago in college and none before yesterday since she stopped drinking and cutting herself five years ago. Her mother has been depressed but there is no family history of suicide. There are no firearms in the home.
- V's psychiatrist is contacted. She confirms the past history and the evaluator's diagnostic impressions. She has just returned to work from maternity leave and can squeeze V. in for an extra session this week.

Diagnoses

I. Major Depression, recurrent, mostly resolved;
Alcohol Dependence, in sustained remission

II. Borderline Personality Disorder--resolving

III. S/P Zoloft overdose

IV. Conflicts with boyfriend and family. Psychiatrist's absence. Abandonment by biological father. Possibly turning 40.

V. GAF : 45 / 45

Risk Assessment

- Victoria is felt to pose no *immediate risk* to herself or others.
- Given her recent history, her *short-term risk* is felt to be moderate at most.
- Given her past history of a serious suicide attempt, recurring episodes of suicidality, her psychiatric diagnoses, social isolation and conflicts, her *long-term risk* without successful treatment could be fairly high.

Critique: the positives

Assessment did touch on:

- Mental status
- Severity assessment of suicide attempt
- History of past attempts; family suicide history
- Current stressors and supports
- Status of current outpatient treatment
- Psychiatric diagnoses
- Other empirically validated risk factors (intense anxiety, insomnia, alcohol, guns)

Common Interventions

- Medication for sleep
- Outpatient therapist to increase frequency of sessions
- Refer Victoria for conjoint therapy with Bill to address conflicts
- Brief hospitalization, Observation, Respite House, stay with a friend.
- Review better coping skills and safety plan

Critique: the negatives

- History of present illness is sketchy. Not clear what it was exactly that caused this overdose or why it happened now at this particular point in her life.
- No formulation of how present stressors are connected to pre-existing vulnerabilities
- Intervention is limited to evaluation and referral; no indication that it was helpful or resolved anything
- Evaluator is still mainly thinking “risk management” and the patient is mainly thinking “convince him to let me go home.”

Possible Outcomes

- Good. Given the rarity of suicide, even in groups known to be at higher risk than the general population, this is not surprising. PCS rate is about 0.04%.

- Bad. "This rarity of suicide [annual incidence in the U.S. is 0.0107%], even in groups known to be at higher risk than the general population, contributes to the impossibility of predicting suicide."*

QUESTION: Can we still improve on our assessments?

*APA Practice Guideline on Suicide, 2003, p. 4

Worst-Case Scenario

- Victoria and Bill get home from PCS to find Jezebel, the 17 year-old daughter of V.'s old college roommate, sitting on the front stoop waiting for them. Jezebel had called V. the week before, saying she would be in town and needed a place to stay. Victoria had reluctantly agreed but had subsequently blocked it out of her mind and had been on on edge without knowing why ever since.

- Jezebel is a high school dropout and is dating the leader of a gang. She has a 2 liter bottle of E & J brandy and some pot with her which she gives to V. as a "hostess present." She also flirts with Bill.

- Bill steps in and says the alcohol is a bad idea, but okays the marijuana because "it's a natural herb."

- ETC

Post-mortems

- Things which we can't control happen after discharge

- Yet it's also true that critical incident reviews suggest the thing most commonly missed in assessments and in treatment was the individual's underlying crisis state of mind, ie, what was really going on and what was really the acute precipitant?

Victoria: Interview #2

- Imagine going back into the interview with a trainee at the point we left off
- Re-conceptualize the Chief Complaint from “Zoloft Overdose” to “Unknown crisis resulting in overdose”
- Don’t give up on the HPI until a thorough search is conducted for an acute precipitant

HPI

- I understand you and Bill had a little argument. What was it about?

  "I don't know."

- These things can be hard to remember.

  "Something little. Something stupid probably. We argue a lot."

- Arguments aren't generally followed by a suicide attempt though, is that right?.

  "No, they aren't. That's right."

- I wonder what it was about this argument that made it especially troublesome.

  "It wasn't just the argument. It's a lot of things. I've been out of work. The house needs repairs. My doctor's been on vacation. My mother calls me all the time to talk about her problems with her husband."

Resistance by diffusion

- Those all sound like important things to discuss at some point. I'd like to focus for the moment on the argument.

"Look, I just want to go home. I'm not suicidal. I'll be fine."

- I think you'd be safest if we can figure out what really set you off so you know what it is and how to be ready for it in the future.

"So I'm your prisoner here, is that it? That just makes me feel worse."

- I want to help free you of the things which are making you a prisoner of yourself.

"I can't focus on that when I feel locked up. How can you keep me here against my will?

- I want you to leave as soon as possible. I just want to make sure it's safe for you to go.

Resistance: cont'd

"Look, I have be at work tomorrow."

- Let's do a little work together right now.

"I don't know what you want to hear." [She stands up.]

- Please sit down. [She sits but remains agitated.]

"Keeping me here is just going to make me feel more suicidal, not less. Is that what you want?

- Thinking and talking about suicide when you're under stress, like you are right now, is really why you're here today. This is what I'm concerned about. That you have a tendency to react impulsively and self-destructively when you're under stress.

"So are you stressing me on purpose? You call that therapy?"

- No, no. I'm really just trying to help. I just want to try to understand what's bothering you.

Dialogue: cont'd 1

"You're bothering me."

- I know this isn't easy. I'll help you."

"You're not helping me. I was starting to feel better. I feel like doctors always focus on people's weaknesses, not their strengths.

- I'm very interested in the strength you have in dealing with the pressures in your life, especially the pressure that tipped you into the state you were in when you took the pills.

"Whatever happened to hoping for the best? That's my motto: 'hope for the best.' What's wrong with that?

- How about hoping for best, but also being prepared for the worst?

"That sounds so trite. What are you really getting at, anyway? It's all bad. What's the worst? I don't even know where to start.

Dialogue: cont'd 2

- Tell me, what happened that day? Let's walk through the events of that day from the beginning.

"Do we have to talk about this? [Impatiently] I just want to go home."

- We don't have to talk about it now, if you don't want to.

"But then you'll make me stay longer, won't you? [She pauses for an answer, but doesn't receive one.] "Okay. Go ahead."

- Let's back up a little, what are you concerned would happen if we were to talk about this?

"I just don't like to talk. I never did."

- [Pause] Can you tell me what it is about talking you don't like?

"Oh, that's good. Talk about why I don't like talking? Where did you get that one?" [Breaks into a smile]

Dialogue: cont'd 3

- [Laughing a little] You're laughing. Maybe you do enjoy talking a little bit…

"I suppose."

- So…do you think you'd rather spar with me than get into other things?

"I don't want to go back into the whole thing…it's a mess [eyes misting up a little]"

- Something hurts you. What are you thinking about?

"Bill was looking at porn on the internet…He wanted me to look at it. 'College girls gone wild.' or something like that."

- Was this something new for him to do?

"No. He does that a lot."

- So what was it about this time?

"I'm not a kid anymore. I still want to get married. Have kids."

Dialogue: cont'd 4

- This has been an issue for some time, I take it?

  "Yeah."
- Is this a more sensitive issue than usual for some reason?

  "I don't know. It's been bothering me for a while."
- I wonder why it would lead to a suicide attempt at this time.

  "I really don't know." [Thinking, but looking uncomfortable]
- Something come to mind?

  "It's nothing really."
- What?

  "My old college friend, had a daughter, Jezebel. Jezebel is coming to visit. She called me the other day. She's trouble with a capital T…She's been into all kinds of things, I hear: drugs, sex, gangs, juvie…big time trouble."

Dialogue: cont'd 5

- That's a lot…

  "I heard she was even in a drive-by."
- You sound pretty worried about her visit.

  "I don't want to get back into all that stuff. And Bill is younger than me…he's even more vulnerable. He's cute and exciting but not very mature, to say the least." [Suddenly, tears well up.]
- What is it?

  "I should have had the child, not Josie. That's Jez's mother. She stole her from me, and look at what a terrible job she did raising her…
- I'm a little confused…

  "Josie slept with my boyfriend in college and got pregnant. I've always felt that I should have had Jez, not her. I've never gotten the baby I wanted. Bill said it would be fun to see Jez all grown up. She's not grown up!
- Wow, that's a lot to be dealing with…

Preconscious Mental Status

- So, exactly what was it that triggered your overdose?

  "Something Bill said."
- Namely?

  [Shaking her head]
- Can't talk about it?

  "No."
- You know, you're here because you sometimes can't put painful things into words. Working to put them into words now will be good for you.

  [Welling up with tears] "Bill told me he thought he had gotten another girl pregnant and it was a rotten deal, and he'd changed his mind about having a child with me."
- And that was the breaking point?

  "Yes. I was hurt, humiliated, enraged, hopeless. I'm almost 40."

Dialogue: cont'd 6

[Breaking down] "I can't bear it."

- [Sitting quietly, then pushing the box of tissue over to her] I know this is really hard for you to talk about.

"I don't know what to do. I can't go home, I don't want Bill to see her. I don't want to see her. I don't want to see Bill. What should I do?"

- That's a really good question. Let's think about it. What thoughts do you have?

"I don't know how to deal with Jezebel's visit. I don't want her to come, but I can't tell her not to. I do kind of want to see her.

- You sound really torn…

"I just want to die. I'm a worthless person. I'm a horrible person, an evil person. I deserve to die.

AND SO ON, OR ALTERNATIVELY--

Alternate preconscious

- Depending on the degree of pathology that is unveiled, the interview could go differently. For example:

"I am really torn. But, you know, as much as I want to see her, and would feel guilty for not seeing her, and feel obliged to help her in a strange way, I've learned enough about my risk for relapse that I have to keep my distance from trouble. And so does Bill. He's fun but he's weak.

- What are you thinking now about how you'll handle her visit? ETC…

Outcomes

- Approaching the interview with a therapeutic mindset helps a patient to tolerate the difficulty and pain of opening up and expanding the HPI. This leads to a better MSE and better diagnoses on Axes IV and V.

- By beginning to help a patient with something important--to begin to tolerate her painful feelings--this interview promotes a therapeutic alliance which is the beginning of treatment and the reduction of risk.

- The interview goes from being adversarial to collaborative. Better treatment decisions are made, including how to cope better with the acute precipitant and at what level of care treatment should begin.

What if no acute precipitant and no revealing preconscious?

- Incomplete diagnosis of Axis IV may be a good reason for admission and a key point for inpatient staff and patients to focus on in treatment
- “Axis IV: Deferred”
- Suspect other etiologies. Malingerers do not have mood-congruent acute precipitants or exhibit the same kind of emotion-laden resistance in the interview.
- Substance-induced mood disorders usually don’t either.

Evaluator Resistances

- It’s hard work to be exposed to intense negative emotions: despair, humiliation, rage, abandonment panic, clinging dependency
- Shortage of beds
- “Not here to do therapy”
- “Patients may exploit this search and use it to enhance their malingering”
- *All of this can lead to unconscious collusion with the patient not to explore the acute precipitant*

Contra-indications

- Not all patients with acute precipitants are amenable to an uncovering type of interview
- Talking about the problem may produce an escalation of frustration and anger
- Hesitancy on the part of the interviewer may be due to sensing this fragility

Some People Need More Preparation

- Medication, eg, minor or major tranquilizer
- More emphasis on establishing trust, eg, offering food, drink, cigarette
- Tag it and leave it alone: “You may find it useful to talk about this another time.”

Implications for training, administration

- In order for clients to learn to acknowledge, bear and put into perspective intensely painful feelings, we must be comfortable with them too.

- Personal psychotherapy or analysis; supervision; experience

- When analyzing a critical incident, such as a suicide, administrators need to ask if the institution promotes the staff's openness and ability to tolerate and work with patient's negative affect states. Are staff trained, supported, not over-worked?